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No. 95-1118

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,

Petitioners,

v.

THE MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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PETITIONERS' REPLY BRIEF

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PETITIONERS' REPLY BRIEF

Although the Attorneys General of twenty-six States, including Wisconsin, as well as the largest health-insurance association in the Nation, have recognized the profound importance and potentially dire consequences of the Seventh Circuit's decision in this case,[1] respondents have attempted to describe the case as merely a private factual dispute of little import. In order to make that claim, they have misstated the holdings of the court below and mischaracterized the record evidence. Regrettably, their argument about "most favored nation" (MFN) clauses descends to *ad hominem* attacks and bald accusations of "plain fabrication" and "disturbing misrepresentation of the record." Br. in Opp'n at 1-2. This reply sets the record straight. *See* Point III.

I. THE RULINGS AT ISSUE ARE NOT FACT-SPECIFIC AND THUS WILL HAVE A BROAD IMPACT.

Rather than confront the enormous potential impact of the Seventh Circuit's decision, respondents assert that the petition "simply challenges two sufficiency determinations" and fails to raise any legal question for this Court's review. Br. in Opp'n at 11; *see id.* at 1-2, 11-15. That assertion is plainly incorrect.

Despite the Seventh Circuit's language purporting to review the record, the court's reasoning is based entirely on supposed economic laws of general applicability. Because the opinion "focuses on theoretical and legal arguments" and "does not contain the traditional apparatus of fact review," *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578, 2591 (1993), there is no basis for distinguishing this case in some future proceeding where it is claimed that health maintenance organizations ("HMOs") are a market or that MFN

[1] *See* Br. of *Amicus Curiae* States of Wisconsin et al. at 1-5 [States' Br.]; *Amicus Curiae* Br. of Blue Cross & Blue Shield Ass'n at 1-2 [BCA Br.].

clauses are anticompetitive. (Pet. 12.) If the ruling was actually based on the absence of evidence, one would expect some discussion of the record.[2] Instead, the court held, in effect, that it does not matter what the witnesses said—theoretical laws of economics must prevail.[3]

Tellingly, respondents are unable to conjure up a single hypothetical fact-pattern in which a physician-owned HMO could be held liable, under the Seventh Circuit's reasoning, for monopolization under Section 2 of the Sherman Act, 15 U.S.C. § 2, or for an unreasonable restraint of trade under Section 1, *id.* § 1. Nor do respondents even attempt to counter Point III of the petition, which explains the potential impact of the Seventh Circuit's antitrust analysis on the future of American health care. *See* Pet. 23-29.[4] Because the court's legal pronouncements cannot be confined to *any* imaginable set of facts, and therefore will have a sweeping and adverse effect on health-care antitrust enforcement, the decision below should be reversed and the jury findings reinstated.[5]

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[2] *Cf. Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986) (summary-judgment movants bear the burden of "'showing'—that is, pointing out to the district court—that there is an absence of evidence to support the nonmoving party's case"). The Seventh Circuit's "fact-free" approach to appellate review stands in sharp contrast to the district court's extensive factfinding and review of record evidence. (Pet. App. 21a-63a.)

[3] The Seventh Circuit's elevation of theory over fact conflicts with decisions of this Court and of other Courts of Appeals. *See, e.g.*, cases cited at Pet. 13-15, 14 n.10, 22, 28.

[4] Even before the Seventh Circuit ruled, Marshfield Clinic's general counsel, Reed E. Hall, had conceded that "[t]his case will have national implications." *Suit Involving Wisconsin Clinic Has Broad Implications*, Rochester (Minn.) Post-Bulletin, Mar. 31, 1995, at 5B.

[5] On November 8, 1995—three weeks *after* modifying its opinion (Pet. App. 64a-65a)—the Seventh Circuit recognized that this case still raises "important question[s] meriting review by the Supreme Court," 7th Cir. R. 41(b)(3), and therefore stayed the mandate pending the filing and final disposition of this petition.

II. THE SEVENTH CIRCUIT DID NOT ENTER ALTERNATIVE HOLDINGS THAT WOULD REQUIRE REVERSAL OF THE TRIAL COURT'S JUDGMENT.

The structure of the opinion below (Pet. App. 1a-20a), as well as that of the special verdict form (Pet. App. 74a-76a),[6] belies respondents' claim that the Seventh Circuit made "alternative holdings" that "independently support the judgment below and would require affirmance no matter how the questions presented were decided." Br. in Opp'n at 2, 15; *see id.* at 15-18. If this Court were to reverse the decision below that no reasonable jury could have found that Security's affiliation agreements and Marshfield's broad pattern of exclusionary practices were unreasonable restraints of trade (Pet. App. 17a), the 1300 physicians employed by or affiliated with Marshfield or Security would clearly have a monopoly share even in the broader "market" defined by the Seventh Circuit (for services provided by physicians to HMO and non-HMO patients), and no issue of market definition or market power could prevent petitioners from obtaining relief.[7] And if this Court were to reverse the decision

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[6] Respondents have never raised any objection to the special verdict form or to the jury instructions regarding the antitrust laws.

[7] After stating that "work for Security generates only 6 percent of [the affiliated] physicians' total income" (Pet. App. 3a; *see* Pet. App. 65a; *see also* Br. in Opp'n at 3, 22), the Seventh Circuit elected to measure market share by reference only to the 400 physicians who own and are employed by the Marshfield Clinic, while effectively ignoring the 900 affiliates who have contracts with Security. (Pet. App. 7a; *see also* Br. in Opp'n at 16 n.13.) The 6% figure is incorrect. *See* Appellees' Pet. for Reh'g at 2-6 (citing extensive record evidence contradicting that figure); *see also* 881 F. Supp. 1309, 1313 (W.D. Wis. 1994) (denying respondents' summary judgment motion).

Moreover, the fraction of the affiliates' income derived from Security does not begin to measure their dependence on Marshfield. Marshfield—which owns or controls most of the hospitals in the region—made it clear that physicians who refused to affiliate on Security's terms would face ruinous competition, the denial of hospital staff privileges, and problems obtaining cross-coverage of

below that no reasonable jury could have found a market for HMO services in north-central Wisconsin (Pet. App. 3a-10a), Security's nearly 90% share of that market (Pet. App. 3a) would easily pass any test of monopoly power (Pet. App. 12a)—regardless of whether the Seventh Circuit's broadly defined "market" had been monopolized by Marshfield and Security.[8] Thus, review of the questions presented here certainly could result in the reversal of the Seventh Circuit's judgment and the reinstatement of the District Court's.[9]

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patients from physicians employed by Marshfield or affiliated with Security. (Pet. 5, 18-21, 27-28; Pet. App. 13a, 28a, 31a-33a, 50a-52a; Tr. 58, 201-16, 483, 713, 925-28.) Furthermore, affiliates are expected to (and do) refer their non-Security patients to the Marshfield Clinic. (Pet. App. 31a-32a; Tr. 1030, 1721; Tr. Exhs. 1841, 10361-10362.) Thus, the jury and the trial court properly concluded that the 900 affiliates, as well as the 400 Marshfield physicians, have been recruited (willingly or unwillingly) into respondents' 1300-physician cartel.

[8] Respondents' argument that Marshfield Clinic is not an "essential facility," Br. in Opp'n at 2, 7-8, 17-18, is a red herring. That issue only arises if one rejects the HMO market and then treats the affiliated physicians as separate from Marshfield. *See* Pet. App. 10a-12a (reaching the essential-facility argument only as a potential fallback *after* holding that Marshfield "is not a monopolist . . . because it does not control its independent contractors and once they are excluded, the Clinic . . . does not have a monopoly of physician services in the north central region or in any parts of the region other than parts too small to support more than a handful of physicians"). Thus, respondents are flatly wrong in stating that the Seventh Circuit's rejection of petitioners' essential-facility argument is "dispositive of all of petitioner Compcare's claims." Br. in Opp'n at 8.

[9] Respondents also misstate the court's holding on the *per se* violation of Section 1 for market division. Respondents claim the court found sufficient evidence of only "a single illegal agreement between Marshfield and the North Central Health Protection Plan" and remanded the case to the district court for a determination of damages "flowing to Blue Cross from that one agreement." Br. in Opp'n at 9-10 (citing Pet. App. 17a-19a). Actually, the court "conclude[d] that the jury verdict on liability must stand insofar as [it concerned] the charge of a division of markets . . . with

III. RESPONDENTS REPEATEDLY MISCHARACTERIZE THE RECORD EVIDENCE PERTINENT TO THE QUESTIONS PRESENTED.

Unlike the decision below, which "merely" disregarded the record evidence and bypassed "the traditional apparatus of fact review," *Brooke*, 113 S. Ct. at 2591, respondents' opposing brief goes one step further and affirmatively misrepresents the facts of the case to avoid review by this Court. *See* Br. in Opp'n at 18-23.

A. The Market for HMO Services in North-Central Wisconsin

With respect to the HMO market issue, there was ample evidence to support the jury's findings, including expert testimony to which the jury and the trial judge gave credence. (Pet. App. 23a-27a.) Respondents' *own internal documents* recognized that competition from a new *HMO* could immediately undercut Security's bloated prices by twenty percent, yet other types of health-care plans were incapable of driving down Security's prices. (Tr. Exhs. 1562, 1563; *see* Tr. 985; *see also* Pet. 3-4 n.3, 19 n.17, 27 n.31; Tr. 1118-22 (undisputed testimony showing Security charged 15% to 75% more than comparable HMOs elsewhere in the State and Nation).) Thus, contrary to respondents' spin, *see* Br. in Opp'n at 16 n.13, this is *not* a case in which defendants' inflated prices could as easily be attributed to "high quality" as to monopolization.

Moreover, as the caselaw makes clear, the mere fact that there is *some* substitutability between HMOs and other forms of health-care delivery and financing, *see* Br.

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competing *plans* or *groups*." (Pet. App. 19a (emphasis added).) The court expressly affirmed the provisions of the district court's injunction that forbade the Clinic to divide markets with the Gunderson Clinic (Pet. App. 55a), the Rice Clinic (*id.*), Wausau area physicians (Pet. App. 55a-56a), Rhinelander Medical Center (Pet. App. 56a), and the Ministry Corporation and its representatives (Pet. App. 57a), as well as the North Central Health Protection Plan (Pet. App. 56a) and "possibly others." (Pet. App. 19a.)

in Opp'n at 19-20, cannot be dispositive: unless the competition is strong enough to constrain the dominant supplier of HMO services (such as Security) from profitably raising its prices significantly above the competitive level, there is a separate product market for HMO services. (Pet. 13-16 (citing *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 481-82 (1992); *United States v. Grinnell Corp.*, 384 U.S. 563, 571-72 (1966); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325-28 (1962); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993)).)[10]

Furthermore, respondents do not even attempt to address the fact that HMOs are controlled by an entirely distinct body of state and federal regulation[11]—a factor this Court has seen as indicative of a separate market. *See United States v. Connecticut Nat'l Bank*, 418 U.S. 656, 660-66 (1974). *See generally* States' Br. at 6-7, 15-17.

Respondents also brazenly mischaracterize the petition when they claim it "ignored" the issue of supply substitution. Br. in Opp'n at 22; *accord id.* at 2, 20 n.14. As the petition explained, Pet. 17-18 & n.14, it is the very

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[10] While largely ignoring the controlling precedents of this Court, respondents cite three district court decisions from the 1980s finding insufficient proof of an HMO market. Br. in Opp'n at 13. None of those cases, however, involved an HMO owned and controlled by an organized group of physicians who were using HMO affiliation agreements and coercive tactics to bring virtually all of their competitors under one umbrella. Pet. 19; Pet. App. 31a-33a, 50a-52a; *see* BCA Br. at 8-11. The Seventh Circuit relied upon its own understanding of "contemporary principles of antitrust law" (Pet. App. 3a) and cited neither the precedents of this Court nor the district court decisions. (Pet. App. 3a-10a.)

[11] *See* Pet. 15, 16-17 & n.12; Pet. App. 23a-24a; Tr. 62, 1111, 2310; Tr. Exh. 4; *see also* 42 U.S.C. §§ 300e-9, 1395mm; 42 C.F.R. § 417.420; Wis. Stat. §§ 49.45(9), 609.96, 613.19, 646.11(2). *See generally* Jon B. Christianson et al., *The HMO Industry: Evolution in Population Demographics and Market Structures*, 48 Med. Care Rev. 3, 29 (1991) (at least 46 States have enacted statutes directed at HMOs).

issue of supply substitution that exposes the critical link between the two questions presented: Marshfield's predatory and concerted actions—especially its *per se* illegal division of markets and its unreasonable use of anticompetitive affiliation agreements—effectively cut off the supply of doctors and thus precluded any competing HMO, such as Compcare, from assembling a comprehensive panel of physicians who could compete effectively against Security's HMO monopoly. (Pet. App. 4a, 27a-28a, 31a-33a, 36a-37a, 50a-52a.)[12]

B. The Anticompetitive Affiliation Agreements and Related Predatory and Concerted Actions

With respect to the affiliation agreements, it is the respondents who engage in "disturbing misrepresentation of the record" when they claim—contrary to the Seventh Circuit's opinion (Pet. App. 16a-17a)—that the agreements between Security and its affiliated physicians do not contain "MFN clauses." Br. in Opp'n at 1-2. Respondents quote from—and even reproduce in an appendix, Opp'n App. 1a (Tr. Exh. 1444)—Paragraph 3.01 of the old *1989* version of the Affiliated Provider Subcontract for physicians in the Greater Marshfield sub-region. Br. in Opp'n at 21. That paragraph appears to set Marshfield's reimbursement at 85% of the provider's "usual and customary charges," which would be roughly consistent with the typical competitive HMO's willingness to reimburse physicians at no more than 80% of list price.

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[12] Respondents incorrectly suggest that all types of "network-based health plans" are "indistinguishable" and that therefore physicians already organized as a preferred provider organization (PPO) or as a point-of-service (POS) plan network could easily "convert to HMOs if it were profitable to do so." Br. in Opp'n at 20 n.14. The Seventh Circuit addressed only PPOs (Pet. App. 6a), and its reasoning is plainly incorrect. (Pet. 11 n.8, 17 n.15.) As to the POS plan, the district court expressly *rejected* respondents' argument that the single POS plan operated by petitioners was a competitive substitute for the comprehensive array of physicians required to form an HMO. (Pet. App. 27a-28a.) The Seventh Circuit did not dispute that conclusion.

(Pet. App. 36a; Tr. 2308.) However, the 1992 (and 1989) versions of the agreements for the three other sub-regions of north-central Wisconsin (NorthCare, Westwoods, and Wausau) all contain other key provisions that respondents conspicuously fail to mention. (Tr. Exhs. 1442-1443, 1527-1530.) Typical of these other provisions are Paragraph 3.02 and Amendment No. 1 of the 1992 agreement for the NorthCare sub-region. (Tr. Exhs. 1527-1528.) Those provisions give affiliates two "options": either receive 85% of "usual and customary charges" with no risk *or* accept a *de minimis* risk of uncollectibles and receive *100%* of those charges. (*Id.*) At trial, there was extensive testimony showing, not surprisingly, that affiliates *routinely* opted for and received 100% reimbursement. (Pet. App. 36a; Tr. 868-70.) Thus, the "85% clause" respondents quote in their brief was almost never invoked; it was simply camouflage for the far more important contractual provisions that respondents' brief strategically ignores.

Furthermore, Security demanded that each affiliate submit his or her fee schedule for pre-approval and, contrary to respondents' arguments, Br. in Opp'n at 22, there was *no* evidence that Security ever approved a fee schedule setting an affiliate's "usual and customary" rate above his or her "lowest" rate. Rather, as the district court found and the Seventh Circuit did not dispute, under Marshfield's scheme the affiliate had *one* price, and it applied to both Security and non-Security patients. (Pet. App. 36a; Tr. at 887-89.) That is precisely how the affiliation agreements served as tools for tacit price collusion.

Thus, the affiliation agreements—specifically, the parts respondents conveniently left out of their brief and appendix—*functioned as MFN clauses,* ensuring Security that it would be treated at least as favorably as any other HMO. *See Connell Constr. Co. v. Plumbers & Steamfitters Local Union No. 100,* 421 U.S. 616, 623-24 & n.1 (1975) (interpreting a contractual provision as a " 'most favored nation' *clause*" because trial testimony

showed that the "primary effect of the agreement" was "to inhibit the [seller] from offering any other [buyer] a more favorable contract" (emphasis added)); *see also* DOJ and FTC Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,788 (Sept. 30, 1994). Tellingly, respondents *never* directly refute the Seventh Circuit's statement that Marshfield and Security "would not pay [the affiliated physicians] more than what these physicians charge their other patients." (Pet. App. 16a.)

The jury and the district judge properly found (Pet. App. 36a), and petitioners accurately argued in the Seventh Circuit, that the practical—indeed, the inevitable —result of the agreements was to stabilize prices for primary-care physician services throughout north-central Wisconsin by "establish[ing] a floor for *all* of an affiliate's charges, *not* just charges to [Security]." Appellees' Br. & Supp. App. at 15 (emphasis in original), *quoted in* Br. in Opp'n at 8-9, 9 n.6. *See generally* VI Phillip E. Areeda, *Antitrust Law* ¶ 1435e, at 229-31 (1986); Jonathan B. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs,* 14 Am. J.L. & Med. 147 (1988). Therefore, the question presented by the petition is correct: the affiliation agreements *did* "require[] [the affiliated] physicians to reduce their lucrative compensation from the dominant HMO [Security] if they accepted lower offers from another HMO" such as Compcare. (Pet. i.) Because the agreements facilitated tacit collusion among some 1300 physicians, created a supracompetitive price floor for medical services throughout north-central Wisconsin, restricted competition that otherwise would have forced prices to drop below that floor, and were buttressed by other predatory and concerted conduct designed to exclude competitors from Marshfield's and Security's markets, the decision below was wrongly decided.

CONCLUSION

This case is not simply a quarrel between an insurer and a group of doctors. Rather, it is a dispute concerning the grossly anticompetitive conduct of the Nation's fifth largest physician-owned clinic. And—as Attorneys General representing a majority of the States and the overwhelming majority of the American people have recognized—it is a dispute implicating the most important antitrust concerns facing American health care today. Accordingly, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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